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ABSTRACT

This report responds to a Minnesota legislative requirement that required the Commissioner, with the advice of the Medical Education and Research Costs (MERC) Advisory Committee, to "develop a system to recognize those teaching programs which serve higher numbers or high proportions of public program recipients and...report to the legislative commission on health care access on an allocation formula to implement this system." The 1996 legislation established the MERC Trust Fund and authorized transfer of the medical education component of the Prepaid Medical Assistance Program (PMAP) and the Prepaid General Assistance Medical Care (PGAMC) capitation rates to the MERC Trust Fund to compensate teaching facilities for some of the costs incurred for training provided in a clinical teaching environment. This report recommends that redistribution of these health care funds be governed by a formula that reflects, equally, the volume of medical education and the volume of public program service. The proposed formula is (education factor x 50 percent) + (public program volume factor x 50 percent) = trust fund percentage. Methods for calculating both factors are explained. Other related policy issues addressed include the rationale for the 50/50 balance between education and public program volume, and treatment of small sites and training sites with no public program revenue. Appended are the relevant legislative excerpts and lists of committee members. (DB)

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Medical Education and Research Costs (MERC)

Recommendations on Distribution of PMAP/PGAMC Funds

A Report to the Minnesota Legislature

February 1998

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Medical Education and Research Costs (MERC)

Recommendations on Distribution of the Medical Education "Carve-Out" from the PMAP and the PGAMC Programs

Executive Summary

Introduction

The Medical Education and Research Costs (MERC) Trust Fund was established in 1996 to provide funding for the clinical training of selected medical professions. The purpose of this funding is to compensate teaching facilities for a portion of the costs of training provided in a clinical teaching environment. These costs that have traditionally been covered by teaching facilities charging higher rates for patient care, a strategy that is becoming more and more difficult as competition increases.

The MERC Trust Fund was established in 1996 and funded in 1997, with $5 million from the General Fund and $3.5 million from the Health Care Access Fund. This one-time appropriation will be distributed in early 1998. Ongoing funding is being sought by the Governor to continue the MERC Trust Fund. These funds are distributed to teaching programs on the basis of the number of eligible trainees and the average cost of clinical training (based on a statewide average for each of the provider types covered by MERC).

In addition to this appropriation, the legislature authorized removal of the medical education component of the Prepaid Medical Assistance Program (PMAP) and Prepaid General Assistance Medical Care (PGAMC) capitation rates, and a transfer of these funds to the MERC Trust Fund. In response to concerns that this would involve a significant redistribution of funds, the legislature determined that there would be a one-year delay in implementation. "Carve-out" and distribution are now set for 1999.

The funds being "carved out" of these two programs were built into the capitation rates to reflect the additional costs of medical education. However, the funds were never tied to health plan utilization of teaching facilities. As such, there was no assurance that these funds were reaching teaching institutions. The legislature authorized removing these funds so that they could be better targeted to medical education providers. The legislation directs that the funds, which are estimated to be approximately $22 million in 1999 will be removed by a reduction in the rates of 6.3% in Hennepin County, 2% in the other metropolitan counties, and 1.6% in the non-metro counties. This differential by region reflects the fact that the medical education payments built into the Medical Assistance (MA) and General Assistance Medical Care (GAMC) rates varied by region. ***It is also important to recognize that these are not new monies to the healthcare system, but represent a redistribution among health care entities.***

In recognition of the fact that these funds will be coming out of PMAP and PGAMC rates, the 1997 Minnesota Legislature required the Commissioner, with the advice of the MERC Advisory Committee, to "develop a system to recognize those teaching programs which serve higher numbers or high proportions of public program recipients and ...report to the legislative commission on health care access on an allocation formula to implement this system." This report is the result of this requirement.

Proposed Distribution Formula

The main objective of the distribution formula developed for PMAP/PGAMC medical education funds is to distribute the funds in a way that fairly reflects both medical education and public program volume, and to do this in a way that is as administratively simple as possible, and as consistent as possible with the process used for the main MERC fund.

- The proposed distribution formula for the PMAP/PGAMC carve-out fund is a simple additive formula which reflects ***equally*** the volume of medical education as well as the volume of public program service.

(Education Factor X 50%) + (Public Program Volume Factor X 50%) = Trust Fund Percentage

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Education Factor: # of eligible trainees multiplied by the average clinical training costs for that provider type divided by the grand total of clinical training costs across all sites. This factor is identical to the standard MERC formula.

Public Program Volume Factor: Each site's total public program revenues divided by the grand total of all sites' public program revenue.

It should be noted that this recommendation differs from the MERC Advisory Committee recommendation. The committee's recommendation was for three-year phase-in process. In the first year, the formula above would be used. In the second year, the weight for the education component would increase to 65% and the weight for public program volume would decrease to 35%. In the third year and beyond, education would be weighted 75% and public program volume 25%.

Although the MERC Advisory Committee recommendation was a well thought out and reasoned one, there were still several significant stakeholders who were not supportive of this distribution formula. Therefore, the Commissioner also consulted with stakeholders in an attempt to build a general consensus and arrive at the best possible recommendation that could be supported by all parties.

Other Components

In addition to the above formula, there are several other related policy issues that should be considered as a part of the distribution process.

- Public Program Revenue should include revenue from Medical Assistance, General Assistance Medical Care, Prepaid Medical Assistance and Prepaid General Assistance Medical Care.

- Training sites that have no public program revenue should be ineligible for a grant from this fund.

- A method should be established to deal with small training sites, in an effort to simplify the distribution process. One option: Grants designated to training sites with fewer than .25 FTEs could be excluded from the requirement that grants be passed on from the teaching program to the training site. This money could then be used by the teaching program to support program activities as deemed appropriate by the teaching program.

The recommendation presented in this report is the result of the input from the MERC Committee process, as well as the additional input from the stakeholders involved, and represents a general consensus recommendation that is supported by the major organizations that provide medical education and public program service in Minnesota. It represents compromise, and it constitutes a fair and reasonable method of distributing these funds.

Medical Education and Research Costs (MERC)

Recommendations on Distribution of the Medical Education "Carve-Out" from the PMAP and the PGAMC Programs

Introduction

The Medical Education and Research Costs (MERC) Trust Fund was established in 1996 to provide funding for the clinical training of selected medical professions. The purpose of this funding is to compensate teaching facilities for a portion of the costs of providing a clinical teaching environment. These costs that have traditionally been covered by teaching facilities charging higher rates for patient care, a strategy that is becoming more and more difficult as competition increases.

The MERC Trust Fund was funded for the first time in 1997, with $5 million from the General Fund and $3.5 million from the Health Care Access Fund. This one-time appropriation will be distributed in early 1998. Ongoing funding is being sought by the Governor to continue the MERC Trust Fund. These funds are distributed to teaching programs on the basis of the number of eligible trainees and the average cost of clinical training (based on a statewide average for each of the provider types covered by MERC).

In the December 1996 MERC report to the Minnesota Legislature, it was recommended that the Department of Human Services (DHS) "direct the medical education 'add-on' funds from the Prepaid Medical Assistance Program (PMAP) and the Prepaid General Assistance Medical Care (PGAMC) Program to the Medical Education and Research Trust Fund for distribution." This "add-on" is a small amount added to each of the HMO rate cells used to determine the appropriate capitation rate for Medical Assistance clients who are enrolled in managed care. Historically there has been a medical education "add-on" to Medicaid fee-for-service rates paid to hospitals in Minnesota. As managed care came in, these add-ons were incorporated into the rate cells used to determine appropriate capitation rates, even ones paid to health plans that do not contract significantly with medical education providers. Thus, some money intended for medical education was never used for that purpose. DHS is in the process of revamping its payment system and is now in the position to be able to pull out that portion of money designated for medical education. Rather than reinventing the wheel in designing a fair payment distribution methodology, DHS has recommended directing these funds to the Medical Education and Research Trust Fund. DHS believes that the MERC Trust Fund represents a more equitable vehicle for distribution of these funds to medical education providers. It is anticipated that directing this PMAP/PGAMC "add-on" to the Trust Fund will result in fewer administrative costs

as well as the potential for better targeting of scarce funds. ***It is important to note, however, that these dollars from PMAP are not new dollars going to medical education.*** Rather, they are dollars that can be used more effectively and efficiently by distributing them through the Trust Fund.

The current estimate of the "add-on" amount that will be transferred to the Trust Fund for distribution in January 1999 is $22 million. The amount will vary each year as the number of PMAP/PGAMC clients increases (due to the anticipated expansion of prepaid programs to the entire state).

The 1997 Minnesota Legislature directed the Commissioner of Health to develop a process to "recognize those teaching programs which serve higher numbers or high proportions of public program recipients and ...report to the legislative commission on health care access by January 15, 1998, on an allocation formula to implement this system." The Commissioner utilized the MERC Advisory Committee to develop that process. The Committee established a "PMAP Subcommittee" to address the relevant issues and tasks. Unlike the MERC Advisory Committee meetings, interested members of the public are invited to actively participate in the subcommittee meetings. With an average attendance at the subcommittee meetings of 25, a variety of perspectives were presented and discussed, with a number of issues being raised in the course of those discussions.

Proposed Distribution Formula

The proposed distribution formula for the PMAP/PGAMC carve-out fund is a simple additive formula which reflects equally the volume of medical education as well as the volume of public program service:

(Education Factor X 50%) + (Public Program Volume Factor X 50%) = Trust Fund Percentage

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Education Factor: # of eligible trainees multiplied by the average clinical training costs for that provider type divided by the grand total of clinical training costs across all sites. This is the standard MERC formula.

Public Program Volume Factor: The sites total public program revenues divided by the grand total of all sites' public program revenue.

Other Components

In addition to the above formula, there are several other related policy issues that should be considered as a part of the distribution process.

- Public Program Revenue should include revenues from Medical Assistance, General Assistance Medical Care, Prepaid MA (PMAP) and Prepaid General Assistance Medical Care.

- Training sites that have no (0) public program revenue should be ineligible for a grant from this fund.

- A method should be established to deal with small training sites, in an effort to simplify the distribution process. One option: Grants designated to training sites with fewer than .25 FTEs could be excluded from the requirement that grants be passed on from the teaching program to the training site. This money could then be used by the teaching program to support program activities as deemed appropriate by the teaching program.

The Process Used to Arrive at this Recommendation

As required by the legislation, the Commissioner of Health consulted the MERC Advisory Committee, which represents key stakeholders in the medical education and health care community. This advisory committee has provided significant advice to the Commissioner on many MERC-related issues, including estimation of medical education costs, development of an application content and process, development of the distribution formulas, and other issues.

In addressing the requirement to recommend a different distribution formula that considers the volume of public program service done by a teaching facility, the MERC Advisory Committee also formed a PMAP Subcommittee. This subcommittee included members of the MERC Advisory Committee as well as a number of other individuals with expertise and interest in public program services.

This subcommittee reported recommendations and several formula options to the MERC Committee. The MERC Committee in turn made a recommendation on a formula to the Commissioner of Health. A list of the membership of MERC and its PMAP Subcommittee is attached.

MERC Advisory Committee Recommendation

The MERC Subcommittee recommendation was that there be a three year phase-in of a distribution formula, which would start with the formula outlined above for the first year. In the second year, the formula would remain substantially the same, however the 50%/50% valuation of the education and public program volume factors would shift to 65% education 35% public program volume. In the third year and beyond these percents would shift to 75% education and 25% public program volume. This approach was intended to reflect that the money was intended primarily for education, but that a transition would be helpful, given the fact that this would redistribute money already in the system and some health plans and/or hospitals would face a reduction in revenue as a result.

Although this recommendation was a well thought out and reasoned one, there were still several significant stakeholders who were not supportive of this distribution formula. Therefore, the Commissioner also consulted with stakeholders in an attempt to build consensus and arrive at the best possible recommendation that could be supported by all parties.

The recommendation presented in this report is the result of the input from the MERC Committee process, as well as the additional input from the stakeholders involved, and represents a general consensus recommendation that is supported by the major organizations that provide medical education and public program service in Minnesota. It represents compromise, and constitutes a fair and reasonable method of distributing these funds.

Issues Involved in the Distribution of the Carve-out Funds

How much emphasis should be on education and how much on public program volume?

One of the primary difficulties the MERC Advisory Committee and subcommittee faced was reconciling the conflicting perspectives of participating entities. Although most participants recognized that the charge was to develop a distribution formula that reflected both teaching and public program volume, there was considerable difference of opinion as to how much each should contribute to the distribution formula. For some, this money was always intended for medical education, and had been paid out unfairly for years to entities that did not provide medical education services. For those that favored this view, the formula should emphasize education, with a small factor recognizing public program volume. For others, this money has been in the public program rates, and regardless of what it was intended for, it is now used for providers of public program services. For those favoring this viewpoint, the formula should reflect primarily the public program volume, with only a small portion of the formula driven by the amount of education performed.

Issue resolution: The recommended formula represents a 50/50 balance between education and

public program volume.

How should public program volume be measured?

Should the measure of public program volume used in the formula focus on PMAP/PGAMC only, or should a broader definition of public program volume be used? The subcommittee discussed the fact that the funds were coming from the PMAP/PGAMC rates, and that perhaps it was logical to only consider PMAP/PGAMC volume in the formula. On the other hand, the MERC application requires audited data from a fiscal year 2 years prior to the distribution year (for example, FY 96 is being used this year for distribution at the beginning of 1998). Because PMAP/PGAMC is expanding, using only PMAP/PGAMC revenues would be unfair for areas just starting prepaid programs.

Issue Resolution: The measure of public program service should include both PMAP and fee for service Medical Assistance revenue.

Treatment of Small Sites

During the application process for the general/access fund distribution, it was learned that educational activities in Minnesota occur in more sites than had been generally known. Although much of medical education activity still is centered in hospitals in urban areas, there are many ambulatory settings in rural and urban areas also serving as training sites for trainees. This is consistent with the interest in broadening the training experiences for medical professionals and in strengthening the focus on primary care, as well as training in rural areas. However, in some cases, training sites are hosting trainees for very short periods of time, resulting in annual trainee FTE counts well below 1.

Some teaching programs rely heavily on short rotations to many different training sites as the best way to get broad training for their trainees. For the PMAP distribution, the sites with very small numbers of trainees could receive a grant in excess of their medical education costs with the inclusion of the public program volume factor in the distribution formula. In addition, the existence of sites with very small grant amounts presents an administrative burden for the sponsoring institutions which would have to cut a large number of checks for small amounts to many sites. For this reason, consideration was given to establishing a cut-off point for sites with very small numbers of trainees. For sites with less than this cut-off number, the grant amount calculated for that site would be at the discretion of the teaching program.

Unlike the rest of the MERC Trust Fund grant, which must be ***passed through*** to the sites of training, the grant amount designated for these small sites could be spent by the program in other ways, or could be passed through to the site. In this way, teaching programs would not be obligated to write checks for small amounts to sites that would not benefit significantly from them.. To evaluate the proper cut-off point for this, we evaluated the effects of eliminating site with less than 1, .5, and .25 FTEs using the first year MERC applications. From this data, we determined that we would eliminate about 200 of the 800 training sites using a .25 cut-off point, these 200 sites represented only about 22 FTEs (out of 2,763 FTEs). Higher cut-off points affected more training sites, but significantly more FTEs were excluded and certain provider types

(in particular advanced practice nurses) were impacted more strongly than others at higher levels. At a cut-off of .25, sites excluded from the pass-through requirement would have had grants ranging between $28 and $1,900. This also seemed more reasonable than higher cut-off points which would have excluded sites with grant amounts of up to $8,000 from the pass-through requirement.

Issue Resolution: Grants targeted to training sites with an eligible FTE count below .25 FTEs would be retained by the teaching program, and could be used to support the teaching program in whatever way the teaching program sees fit.

Training Sites with No Public Program Revenue

A concern was raised within the MERC Advisory Committee discussions that organizations that do not provide service to public program clients at all could qualify for a grant under the distribution formula. Because the funds are coming from public program rates, some felt that this would be inappropriate. Others felt that it would be inappropriate to eliminate such training sites, because the real value of medical education to the public programs occurs after training is done and the practitioners are out in the field providing health care services. Through discussions with the MERC Committee, it was concluded that as long as the measure of public program revenues included revenues for fee-for-service MA and GAMC as well as the prepaid programs, few sites would be eliminated with this requirement.

Issue Resolution: Training sites that have no (0) public program revenues would be ineligible for funding from this source.

APPENDIX A

Medical Education and Research Cost (MERC) Legislation

SF 1908 Health and Human Services Omnibus Appropriation Bill

Article 2

Sec. 3 Minnesota Statutes 1996, section 62J.69 amended by adding a subdivision to read:

Subd. 3. **Medical assistance and general assistance service.** The commissioner of health, in consultation with the medical education and reserach costs advisory committee, shall develop a system to recognize those teaching programs which serve higher numbers or high proportions of public program recipients and shall report to the legislative commission on health care access by January 15, 1998, on an allocation formula to implement this system.

APPENDIX B

1997 MERC ADVISORY COMMITTEE MEMBERS
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John Abenstein, Mayo Clinic
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Kent Crossley, Veterans Affairs Medical Center
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APPENDIX B

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